

## **DEPENDENT/ ADOPTED CHILD FORM**

DO NOT USE – FOR INTERNAL PURPOSES ONLY
HIOS ID#

✓ CHECK DESIRED ACTION         ☐ (FD) Add Dependent       Please complete this application for Dependent /Adopted child membership         Desired Eff Date       /	P.O. Box 21146, Eagan, MN 55121	
General Totals	A nonprofit independent licensee of the BlueCross BlueShield Association	
Desired Eff Date		
PAGE Adopted Dependent   Desired Eff Date   Page		
Desired Eff Date  ### Date of MINTER COMPLETED  ### Sex		11, 14114 33121
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ocial Security #		
ast Name   First N	SUBSCRIBER INFORMATION – MUST BE COMPLETED Married: Yes No Date of	marriage marriage
ast Name   First N	Social Security #  F Birthdate:	
itreet		
Nork Phone Number		
Nork Phone Number	Street Street	
Home Phone Number		
Interest		
Are you a Current Patient of PCP?  Are you a Current Patient of Ob/Gyn?  Yes No Yes No  Male Date of Birth Social Security Number Is your over-age dependent handicapped or disabled?  Yes Female (See last page for additional information) No schild a Foreign Exchange Student? Yes No, If yes, request coverage from to to The Patient of Coverage in the Sudent?  Our may be contacted for additional information. In addition, please provide a copy of your "Certificate of Coverage" from your former dental forurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No  Insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No  Insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No  Insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No  Insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes No  Insurance carrier or employer. Are you or any member of your family enrolled in any other health or dental insurance policy (including Medicare or Medicaid)? Health? Yes No /Dental? Yes	work Priorie Number Home Priorie Number	
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Primary Care Physician's Last Name Primary Care Physician's First Name Ob/Gyn's Ob/Gyn's		M.I.
Ob/Gyn's Last Name		
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(B) Excellus BlueCross BlueShield		d and Family
	✓ Check previous insurance company from list below and indicate ID #:	
(O) Other - Blue Cross Blue Shield Plan. Indicate Plan Name:	(B) Excellus BlueCross BlueShield	
	(O) Other - Blue Cross Blue Shield Plan. Indicate Plan Name:	
(C) Other Carrier - Indicate Plan Name:	(C) Other Carrier - Indicate Plan Name:	

adopted child, or a child that has been placed with you for adoption.
Acceptable legal documentation includes:  For legal guardianship
A copy of the court order that conveys legal guardianship of the child to the subscriber or spouse. Custody agreements or orders do not convey
legal guardianship
For an adopted child  A copy of court documents signed by a judge showing that the subscriber has adopted the child; or international papers from the country of
adoption; or papers from adoption agency showing intent to adopt.
and provide the provided and the second seco
1. Relationship to Subscriber
2. Mother's Last Name First Name
Mailing Address
City State Zip
Date of Birth
3. Father's Last Name First Name
Mailing Address
City State Zip
Date of Birth
Adaption Incompation of the adeption proceedings. I hereby apply for the
<b>Adoption</b> – Inasmuch as I am legally obligated to support this child during the period prior to completion of the adoption proceedings, I hereby apply for the inclusion of this child as a family member under my health plan.
<b>Legal Guardianship</b> - A child for whom the subscriber is the legal guardian is eligible. Please note custody alone is not sufficient. A court must specifically
confer legal guardianship. The child is eligible for coverage the date of the court order.
Please submit your acceptable legal documentation along with this form (placement agency papers, letter from law firm/attorney on law firm/attorney letterhead, papers from country of birth).
I hereby certify that on the date (mm/dd/yy) of I began legal proceedings for the adoption of the child noted above.
DEPENDENT – I hereby apply for inclusion of this child as a family member under my health plan. I agree to notify Excellus BlueCross BlueShield when a
change in status occurs.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim
containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent
insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.
Subscriber SignatureDate

DEPENDENT CHILD - Please complete this section if you are applying for coverage for a child for whom you are the legal guardian or for an

If you have any questions, please contact your Group Administrator/Representative.

Or, visit us at: www.excellusbcbs.com